



## INVITED COMMENTARY

# Comments regarding “A Systematic Review of Implementation of Established Recommended Secondary Prevention Measures in PAOD”

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Submitted 8 October 2009; accepted 12 October 2009

Available online 10 November 2009

The conclusion of this systematic review is that there is a paucity of high quality studies to assess the extent to which patients with peripheral arterial occlusive disease (PAOD) receive secondary preventive therapy. Few of the studies were prospective, most were cross-sectional and/or retrospective and none were randomized. Nevertheless, this review demonstrated what many of us have already suspected; patients with PAOD rarely receive appropriate medications and/or life-style guidance according to professional guidelines.<sup>1,2</sup>

We still do not know why this should be the case and we remain at a loss to know what further measures should be taken in order to meet the challenge of ensuring that each PAOD patient receives appropriate guidance that will reduce their risk of secondary cardiovascular events. We can propose that there might be a lack of knowledge amongst vascular surgeons. Perhaps surgeons who are comfortable at performing complex procedures feel somewhat out of place in dealing with the treatment of multiple co-morbidities (hypertension, hyperlipidaemia etc). Some may be reluctant to offer patients advice about diet, smoking cessation and exercise. Perhaps surgeons are resistant to starting four or five new medications in a patient who has walked into their consulting room having taken none beforehand. Perhaps there is not enough time in a busy outpatient clinic for the surgeon to devote enough attention to secondary preventive

measures and, perhaps, patients do not follow advice that has been given in a hasty or superior manner.

So how might we, as a profession, increase the proportion of patients receiving secondary preventive therapy in routine clinical practice? From previous research, it is evident that strong leadership is required by the Departmental Head,<sup>3</sup> supplemented by easily accessible knowledge sources and reinforcement of the importance of secondary prevention at educational meetings.<sup>4</sup> It is also likely that continuously auditing how successful the secondary prevention programme is, together with feedback to the responsible surgeon, will increase the success rate.<sup>5</sup> It may also be necessary to think completely differently. Maybe other Healthcare professionals could take this burden off the surgeon? For example, a Nurse led secondary prevention clinic, supervised by a surgeon/physician, has already been successfully established in Copenhagen.<sup>6</sup> Alternatively, maybe this might be an ideal role for an Angiologist? Clinics that provide time to educate and guide patients so that they can make the right lifestyle choices in an effective way should be encouraged, in order that patients are then able to develop an understanding of the nature of their vascular disease and then take personal responsibility for their care.

Unfortunately, we still do not know which strategy will best increase the rate of implementation of secondary prevention guidelines and further studies in this field would be very helpful. If nothing else, this systematic review has shown that the current situation cannot be allowed to

DOI of original article: 10.1016/j.ejvs.2009.09.027.

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continue and every Vascular Unit should critically review their practice.

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